

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

214

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 05275											
1 - FOR STATE REGISTRAR										REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR								
Delta		Josephine				Brown		February 21, 1985					4:40P M								
3. SEX		4. RACE		5. DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
Female		White		MONTH March		DAY 4		YEAR 1898		MONTHS		DAYS		HOURS							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.									
Phillippi, W. Va.		USA		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		Garrett													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)								12b. KIND OF BUSINESS OR INDUSTRY									
Oakland		Garrett County Memorial Hospital		Housewife								Own Home									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE W. Va.		13b. COUNTY Marion		13c. CITY OR TOWN Fairmont		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 205 Edison Street 26554		99999	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
FIRST Amos										FIRST Alcinda		No		538-24-7277		George Ware		Bolton East Park Avenue		100	
LAST Mathew										LAST Fairmont, W. Va. 26554											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)									
										Cerebrovascular disease		4/23									
20. DATE OF OPERATION										20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/>		NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (he) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE										DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Thomas G. Johnson, M.D.																		2/22/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS											
Thomas G. Johnson, M.D.										Fourth Street		Oakland, Maryland 21550									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE			
Burial										2/23/85		Woodlawn Cemetery		Fairmont		FEB 28 1985		Julia Johnson			
24. FUNERAL DIRECTOR NAME										ADDRESS											
Durst										Oakland, Maryland											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PAPER. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										8 5 0 5 2 7 6			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR
Leta Marie Brown								<input type="checkbox"/>		2	27	85	655P
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. HOUR				
female	white	01-13-1906	79 yrs	MONTHS	DAYS	2 27	1985	710PM					
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA						Garrett					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (INCLUDE FACILITY, ONE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Oakland		Cuppert-Weeks Nursing Home		housewife		Own home							
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Grand Avenue 21502					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST					
Edward B. Spicer						Zeta Stanley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		214-07-1171		Mrs. Mary Ketterman, Cumberland, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>										TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M. D.										DATE SIGNED 2-27-1985			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 03-04-1985		23c. NAME OF CEMETERY OR CREAMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN Cumberland		COUNTY Allegany		STATE MD			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR James F. Scarpelli, Cumberland, MD 21502		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							
20M 4/B2				MAR 04 1985									
DHMH - 17 (VR A15 ME (5))													

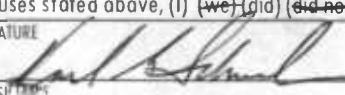
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

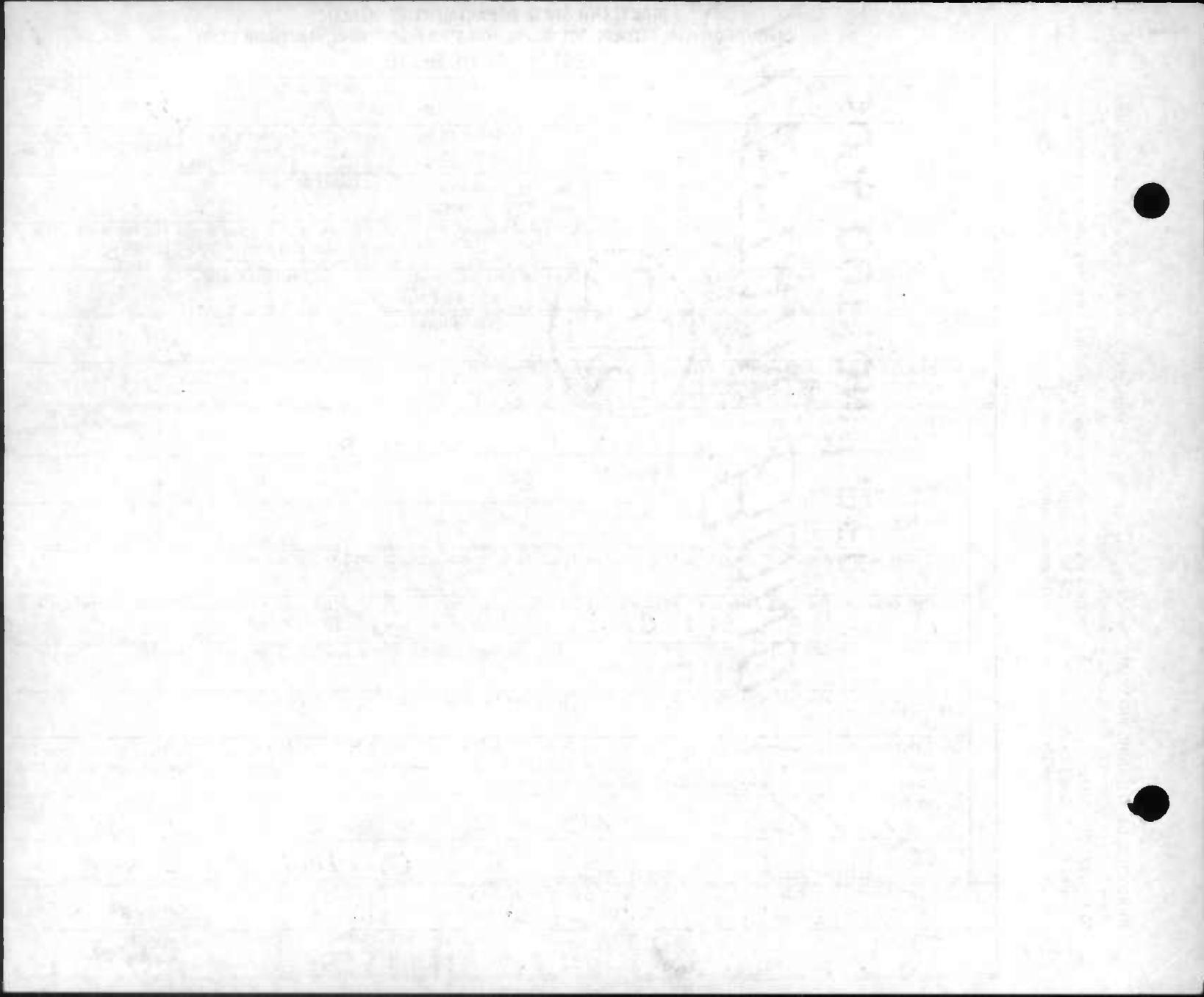
CERTIFICATE OF DEATH

1 2 5 2 7 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and may be filed within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Eldred	Middle Sterling	Lost Burns	20. DATE OF DEATH Feb 1 1985	2b. HOUR M	
3. SEX Male		4. RACE White		S. DATE OF BIRTH Feb. 22 1913	6. AGE (In years lost-birthday) 71 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Garrett Co.		
10. CITY OR TOWN OF DEATH Kitzmiller		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Main St.		12. USUAL OCCUPATION (Kind of work done during last of working life, even if retired) Goodyear Tire Co. Tire		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Garrett		13c. CITY OR TOWN Kitzmiller	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Main St. 21538	
14. FATHER'S NAME Edward		Middle Burns	Lost	15. MOTHER'S MAIDEN NAME Hazel	Middle	Lost Roderick	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Patricia Brady	Address Kitzmiller Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to the Liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION 1/18/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Suspected Ct/Wt. Loss		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 19 85</u> to <u>1/31 19 85</u> , that (I) (we) last saw the deceased alive on <u>1/27 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		MD DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2/1/85
22d. PHYSICIAN'S NAME (Type) Karl F. Schwalm		22e. ADDRESS Oakland, MD 21550					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-3-85		23c. NAME OF CEMETERY OR CREMATORIAL IOOF Cemetery		23d. LOCATION (City or Town) Elk Garden	
24. FUNERAL DIRECTOR David A. Burdock		ADDRESS Kitzmiller, Md.		25a. REC'D BY REGISTRAR FEB 11 1985		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or hem 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8505278				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			CARTER			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Edna			VIRGINIA			CARTER						February 7 1985				6:20p.m
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH OCT			YEAR 1911			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Garrett				MD.
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppett-Weeks Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE				
13a. STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD# 5 WINCHESTER ROAD				
14. FATHER'S NAME FIRST IRA			MIDDLE			LAST COSNER			15. MOTHER'S MAIDEN NAME DELCTA			ADDRESS CUMBERLAND MD. 21502			MCNEMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 232-22-0865			17. INFORMANT CARROLL TAYLOR RFD5 WINCHESTER ROAD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1hr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>																
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Thrombosis</i>															gr	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>															gr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 19 83</i> to <i>Feb 6 1985</i> , that (I) (we) last saw the deceased alive on <i>Feb 6 1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																
22b. SIGNATURE <i>B.L. Grant MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/7/85							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B.L. Grant MD</i>			22f. ADDRESS Third St. Oakland, Maryland 21550													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB 11 1985			23c. NAME OF CEMETERY OR CREMATORIAL REST LAWN MEMORIAL PARK LAVALE ALLEGANY MD.			23d. LOCATION CITY OR TOWN COUNTY			STATE				
24. FUNERAL DIRECTOR NAME ST. COX-MERRITT FUNERAL SERVICE CUMBERLAND MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 13 1985			25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>							
DHMH-16 50M 7/77 (VRA 15 (4))																

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G. R. Gandy

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Constitutive and Intrinsic Properties of the Cell Membrane

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed with

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 05279	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Mary Elizabeth Casseday						February 25, 1985			2:15p M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		November 21, 1897			87 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			MD	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Domestic				
13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Mt. Lake Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1207 Oakland Ave. 26764		
14. FATHER'S NAME FIRST Ulysses		MIDDLE Grant		LAST Myers			15. MOTHER'S MAIDEN NAME FIRST Isabelle			LAST Mankins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 233-19-6487		17. INFORMANT Bernice Melchek			ADDRESS Box 334			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE		20. DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a LEFT ILIAC ARTERY EMBOLUS											
19a. DATE OF OPERATION 2/21/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ISCHEMIC LEFT LEG			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from 2/21/85 to 2/25/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>John C. Porcary</i>		22c. REGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/25/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN C. PORCARY		22e. ADDRESS 311 N 44 ST OAKLAND MI									
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial		23b. DATE Feb. 28, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Camp Chapel Cemetery			23d. LOCATION CITY OR TOWN Tunnelton		COUNTY Preston		STATE WV
24. FUNERAL DIRECTOR <i>John K. Whitehair</i>		25a. ADDRESS Terra Alta, WV			25a. DATE REC'D. BY REGISTRAR MAR 04 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8505280	
										REG. NO.	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		Feb. 7, 1985		9:15 P.M.
Ada Belle Duppstadt											
3 SEX F			4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE COUNTRY Pa.			7b CITIZEN OF WHAT COUNTRY? USA		7c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7d 79		7e YRS		
8a CITY OR TOWN OF DEATH Grantsville			8b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Goodwill Mennonite Home		8c 9a BALTIMORE CITY OR COUNTY OF DEATH Garrett Co		9b USUAL OCCUPATION Homemaker		9c 12b KIND OF BUSINESS OR INDUSTRY		MD.
10a STATE Md.			10b COUNTY Garrett		10c CITY OR TOWN Grantsville		10d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10e STREET ADDRESS Goodwill Mennonite Home		11a 12a 21638
11a FATHER'S NAME Morgan			11b MIDDLE Dickey		11c 15a MOTHER'S MAIDEN NAME Emma		11d 15b MIDDLE Stuck		11e LAST		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN NO			16b SOCIAL SECURITY NO 180-28-2384		17 INFORMANT David Duppstadt RD-3 Meyersdale, Pa.		17b ADDRESS		18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18b		18c		18d		18e		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)		(c)		(d)		(e)		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20c		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Thomas L. Miller			m D		22c DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED		7 Febr 85
22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas L. Miller			22e ADDRESS Grantsville, Md.								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Feb. 10-85		23c NAME OF CEMETERY OR CREMATORIAL Hays Church Ceme.		23d LOCATION CITY/TOWNSHIP Berlin RD		COUNTY Somerset Co.		STATE Pa.
24 FUNERAL DIRECTOR John Davidson			25a ADDRESS 325 Main St. Meyersdale Pa. 15552		25b DATE REC'D. BY REGISTRAR FEB 28 1985		25b. REGISTRAR'S SIGNATURE John Davidson				
25a			25b		25b		25b				

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1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Floyd Chester Foley							February	4	1985		12:20am
3 SEX	4 RACE	5. DATE OF BIRTH									
Male	White	MONTH DAY YEAR March 14, 1903									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
W. Va.	USA		81	MONTHS	DAYS	HOURS	MIN.	YRS.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY			
Gorman	Box 15 Gorman (Mailing Address)						Miner	Coal			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE							
Md.	Garrett	Gorman	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Box 15 (Gorman, W. Va.) 2672							
9. BALTIMORE CITY OR COUNTY OF DEATH Garrett M.D.											
14. FATHER'S NAME FIRST MIDDLE LAST											
Homer	DeSoto	Foley	15. MOTHER'S MAIDEN NAME								
Dora	Belle	Manks									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT	ADDRESS				
No			213-03-0466A			Mrs. Luvada Foley - same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of the lung's</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastasis</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/16/85, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.				19 46 to 4 26 19 85							
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS						5/16/85			
A.E. Mance, M.D.		Third St.		Oakland, Maryland 21550							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY	23f. STATE		
Burial		2/6/85		White Church Cemetery (rural)		Oakland		Garrett	Md.		
24. FUNERAL DIRECTOR NAME <i>Ronald M. Mance</i>											
Durst Funeral Home Oakland, Maryland 21550											
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 11 1985 <i>Julia Luvada Rendall</i>											

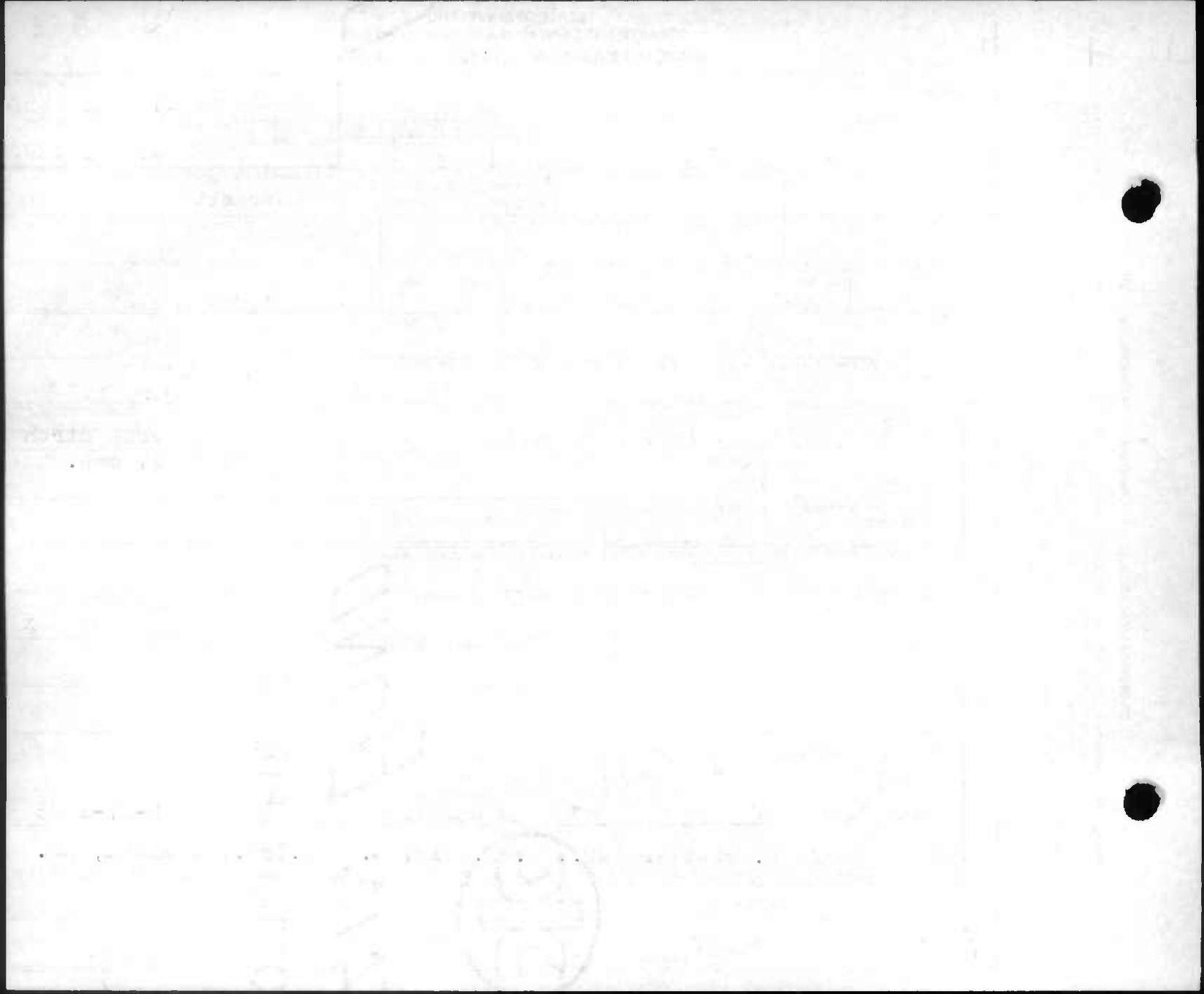
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL BY FUNERAL HOME, MARYLAND, 21201

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												3 5 0 5 2 8 2							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR		
Samuel			Douglas			FRAZEE			<input checked="" type="checkbox"/>		2 17	19	85	945AM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR	
Male		White		9-2-1983			1 YRS.						2 17		19	85	130PM		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland			USA						Garrett										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Friendsville			Rt. 1, Box 106 A (Rural)			infant													
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Maryland			Garrett		Friendsville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 106 A, 21531									
14. FATHER'S NAME FIRST			MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Douglas			Eugene		Frazee			Martha		Marie		Sines							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
No			---			none			Rt. 1, Box 106 A Douglas E. Frazee, Friendsville, MD 21531										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Menkes Syndrome												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH From birth							
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>												17 mos.							
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?													
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held an												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>												TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M.D.												DATE 2-17-1985 SIGNED							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY			STATE				
Burial			2-19-1985			Blooming Rose Cemetery			Friendsville, Garrett, MD										
24. FUNERAL DIRECTOR NAME <i>D. Lynn Feaster</i>			ADDRESS <i>Grantsville, MD</i>			25a. DATE REC'D. BY REGISTRAR FEB 25 1985			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendleton</i>										

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(VR A15 ME (5))
20M 4/B2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 more lie

rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8505283
						REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR
Edward Russell HARRIS						21 Feb 85
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		2b. HOUR 11:00 AM
Male		White		Apr. 10, 1907		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.
Maryland		USA				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Contract
Oakland		Garrett County Memorial Hospital				12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. STATE Md.		13b. COUNTY Garrett		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE Rt. #2, Box 274 21561
14. FATHER'S NAME FIRST Jesse		MIDDLE -----		LAST Harris		15. MOTHER'S MAIDEN NAME FIRST Mary
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		MIDDLE Florence ADDRESS Murphy
No		219-03-9681		Mrs. Ruby G. Harris, See #13 above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, fatal bronchial</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiac vascular disease</i> BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Arteriosclerosis</i> days years years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTRY		
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 1950 to 21 Feb 1985, to <input checked="" type="checkbox"/> that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did not view the body after death.						
22b. SIGNATURE <i>Edward Mance</i>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 2/24/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. E. Mance, MD		22e. ADDRESS Third Street, Oakland, Maryland 21550				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/24/85		23c. NAME OF CEMETERY OR CREMATORIAL Murphy Cemetery		23d. LOCATION CITY OR TOWN Swanton, Garrett, Maryland
24. FUNERAL DIRECTOR NAME Bradley A. Stewart		ADDRESS Oakland, Maryland 21550		25a. DATE REC'D. BY REGISTRAR FEB 28 1985		
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 05284								
											REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			16a. DATE OF BIRTH			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
<i>John (unknown)</i>			<i>Knodel</i>			Dec. 27 1899			<i>February 15 1985</i>			12.12p								
3. SEX MALE			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR			16. AGE (IN YEARS LAST BIRTHDAY)			17. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			16. AGE (IN YEARS LAST BIRTHDAY)			17. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppert & Weeks Nus. Home.			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN Oakland			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7th & Alder Streets 21550					
13a. STATE Maryland			13b. COUNTY Garrett			13c. CITY OR TOWN Oakland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7th & Alder Streets 21550			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never worked			12b. KIND OF BUSINESS OR INDUSTRY Invalid		
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Knodel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia (unknown)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 193-40-0907			17. INFORMANT Louis R. Knodel			18. ADDRESS 403 Center Way Lake Jackson, Texas 77566			19. PREVIOUS INTERVAL BETWEEN DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>			20. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary emphysema</i>			21. DUE TO, OR AS A CONSEQUENCE OF (c)			22. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic Brain Syndrome</i>											
19a. DATE OF OPERATION			19b. CONDITION IN WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from <i>mar 19 79</i> to <i>Feb. 19 85</i> , that (I) (we) last saw the deceased alive on <i>Feb 13 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.			22b. SIGNATURE <i>B.L. Grant, M.D.</i>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>Feb 15, 85</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2/18/85			23c. NAME OF CEMETERY OR CREMATORIAL Beinhauer Crematory			23d. LOCATION CITY OR TOWN Pittsburg			23e. COUNTY Allegheny			23f. STATE Pa.					
24. FUNERAL DIRECTOR NAME Durst Funeral Home			25a. ADDRESS Oakland, Maryland			25b. DATE REC'D. BY REGISTRAR FEB 20 1985			25c. SIGNATURE John Davidson											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

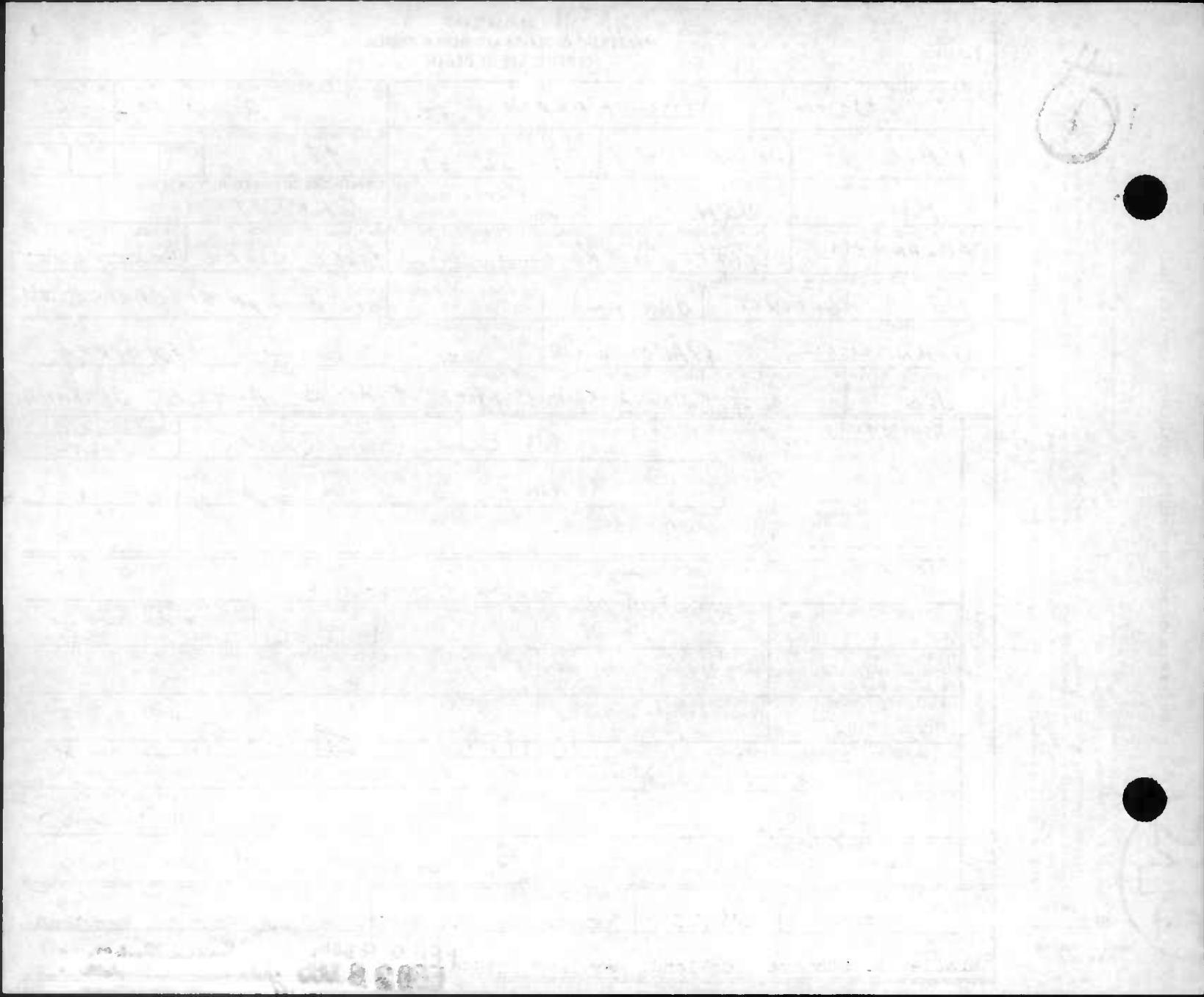
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8505285			
1 - STATE REGISTRAR						REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Rufus		J.		Losh, Sr	2	2	85		M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.
Male	White	2	19	85	78	YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	Garrett			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Oakland	Garrett Co. Memorial Hospital			Laborer			99999		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE						13e. STREET ADDRESS / ZIP CODE			
Weston						102 Mayer Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
William		David		Losh		Ellie H. Helmick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		218-05-7097		Sandra Kelly, Terra Alta, WV		26764			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Heart Failure						Hours.			
DUE TO, OR AS A CONSEQUENCE OF (b) Abscess of Lung						months			
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cerebrovascular disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>85</u> , to <u>Feb. 2</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Jan</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Thomas J. Mance</u>						DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
Thomas J. Mance, D.O.						22e. ADDRESS 3 South Third St. Oakland, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Terra Alta Cemetery		23d. LOCATION Terra Alta Preston WV		STATE	
Burial		2-6-85							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 1 1985		25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall			
John K. Kehlback		405 Highland Ave Terra Alta, WV 26764							
DHMH 16 60M 7 84 (VRA 15, 4)									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 05286
1. FOR STATE REGISTRAR John William Maroney, Jr.										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		FIRST John	MIDDLE William	LAST MARONEY, Jr.	2a. DATE OF DEATH MONTH 2 DAY 16 YEAR 85		2b. HOUR 930A M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 9 DAY 26 YEAR 07		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH GARRETT MD				
10. CITY OR TOWN OF DEATH OAKLAND, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CUPPETT WEEKS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing Home STORE CLERK		12b. KIND OF BUSINESS OR INDUSTRY Grocery Store				
13a. STATE Md.		13b. COUNTY GARRETT		13c. CITY OR TOWN OAKLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 615 E. 6th ST. OAKLAND, Md.		
14. FATHER'S NAME John William		15. MOTHER'S MAIDEN NAME HARONEY SR.		16. SOCIAL SECURITY NO. WW II		17. INFORMANT CUPPETT & WEEKS		ADDRESS ALDER ST. OAKLAND.		
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Queensboro C Sept 24th Advanced Cerebrovascular w/ yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.		DUE TO, OR AS A CONSEQUENCE OF (b)								
		DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Rev. V. Jesner Disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 10/11/84		21f. LOCATION STREET CITY OR TOWN CITY OF BALTIMORE COUNTY STATE						
22a. I certify that (I) <input type="checkbox"/> offended the deceased from saw the deceased alive on 2/15/85 19 above, (I) <input type="checkbox"/> did not view the body after death.										19 10/11/84 19 19 19 19
22b. SIGNATURE H.K.		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 2/16/85
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Johnson		22f. ADDRESS 311 W. North St. Oakland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/19/85		23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gards.		23d. LOCATION CITY OR TOWN Oakland, Garrett, Maryland		23e. COUNTY 23f. STATE		
24. FUNERAL DIRECTOR NAME Bradley A. Stewart ADDRESS Oakland, Maryland 21550										25a. DATE REC'D. BY REGISTRAR FEB 28 1985 25b. REGISTRAR'S SIGNATURE Julia Davidson-Pender



TO HOSPITAL OR ATTENDING PHYSICIAN. The

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be removed within 24 hours after death. Page 4 may be informed by the hospital or attending physician.

TO FUNERAL DIRECTOR After the certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the 72-hour death record with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows only injury, or other traumatic event, the medical examiner, who is bound by law,

DMMH - 16 60M 7/B4
(VRA 15, 4)

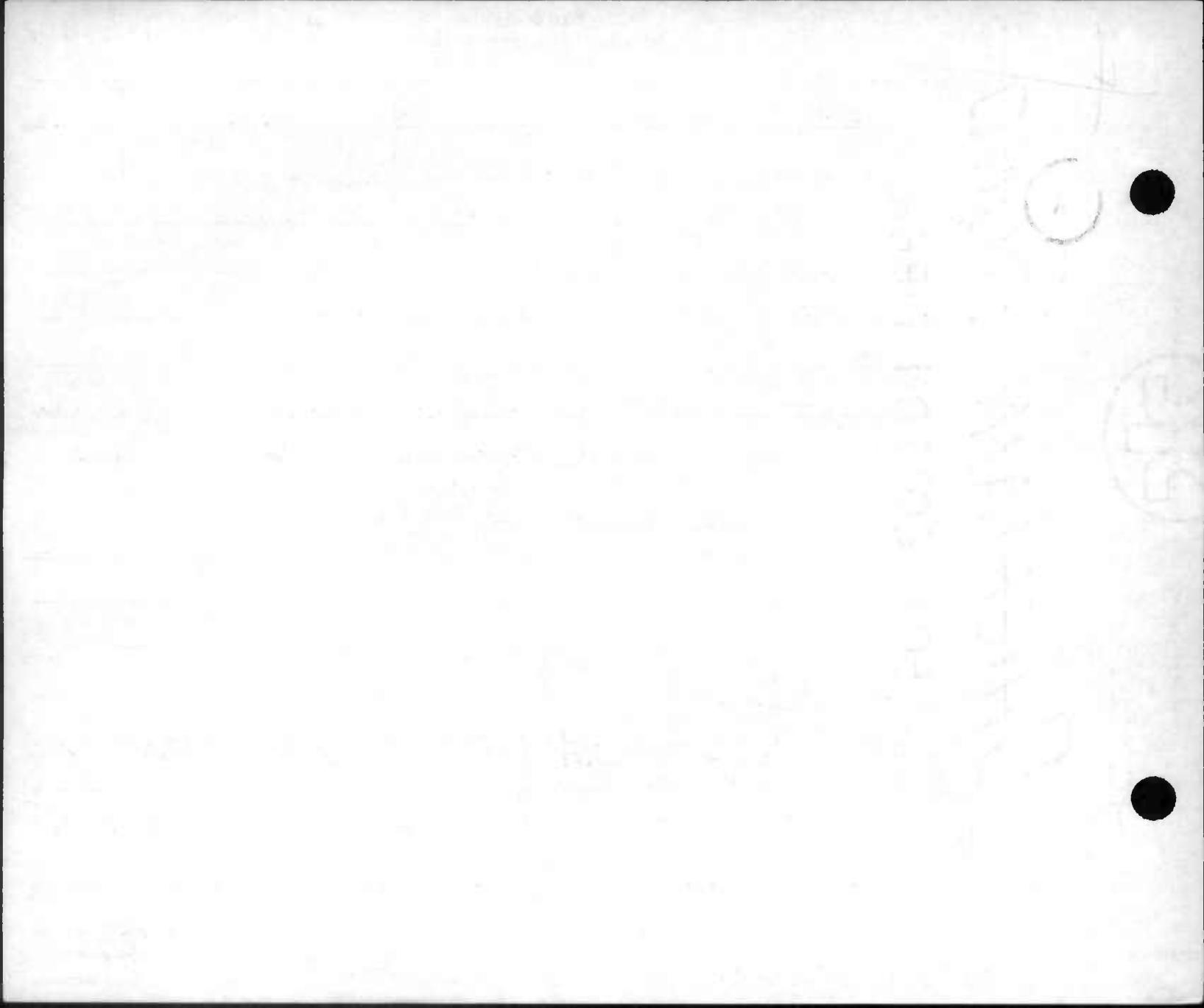
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRY

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 2 8 7

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Carl Frederick Miller						Feb. 8, 1985				6:50p.m.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
M		W		Feb. 26, 1907			77 yrs						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Md.		USA					Garrett County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Oakland		Garrett County Memorial Hospital				Farming				Farm			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE							
13b. COUNTY						13c. CITY OR TOWN							
Md.						Garrett Accident							
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE							
						Rt. 1, Box 10							
21520													
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
William				Miller	Barbara				Kahl				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			213-24-5387			Mrs. Mabel Miller, Rt. 1, Box 10, Accident, Md.			21520				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY.						IMMEDIATE CAUSE (a) <i>Cardiac failure</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
						IMMEDIATE CAUSE (b) <i>Ami</i>						3 days	
						IMMEDIATE CAUSE (c) <i>ASHD</i>						3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED <input type="checkbox"/> WHILE WORKING <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/1/05</i> to <i>2/8/05</i> , 19 <i>05</i> , that (I) (we) last saw the deceased alive on <i>2/8/05</i> , 19 <i>05</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>TGJ</i>		22c. DEGREE				22d. DATE SIGNED <i>2/11/05</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Thomas G. Johnson, M.D.		311 N. 4th St., Oakland, Md. 21550											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE			
Burial		2-11-85		Zion Church Cemetery		Accident, Garrett, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR							
Ruth K. Neumann		Grantsville, Md.				25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Pendleton</i>							
FEB 13 1985													

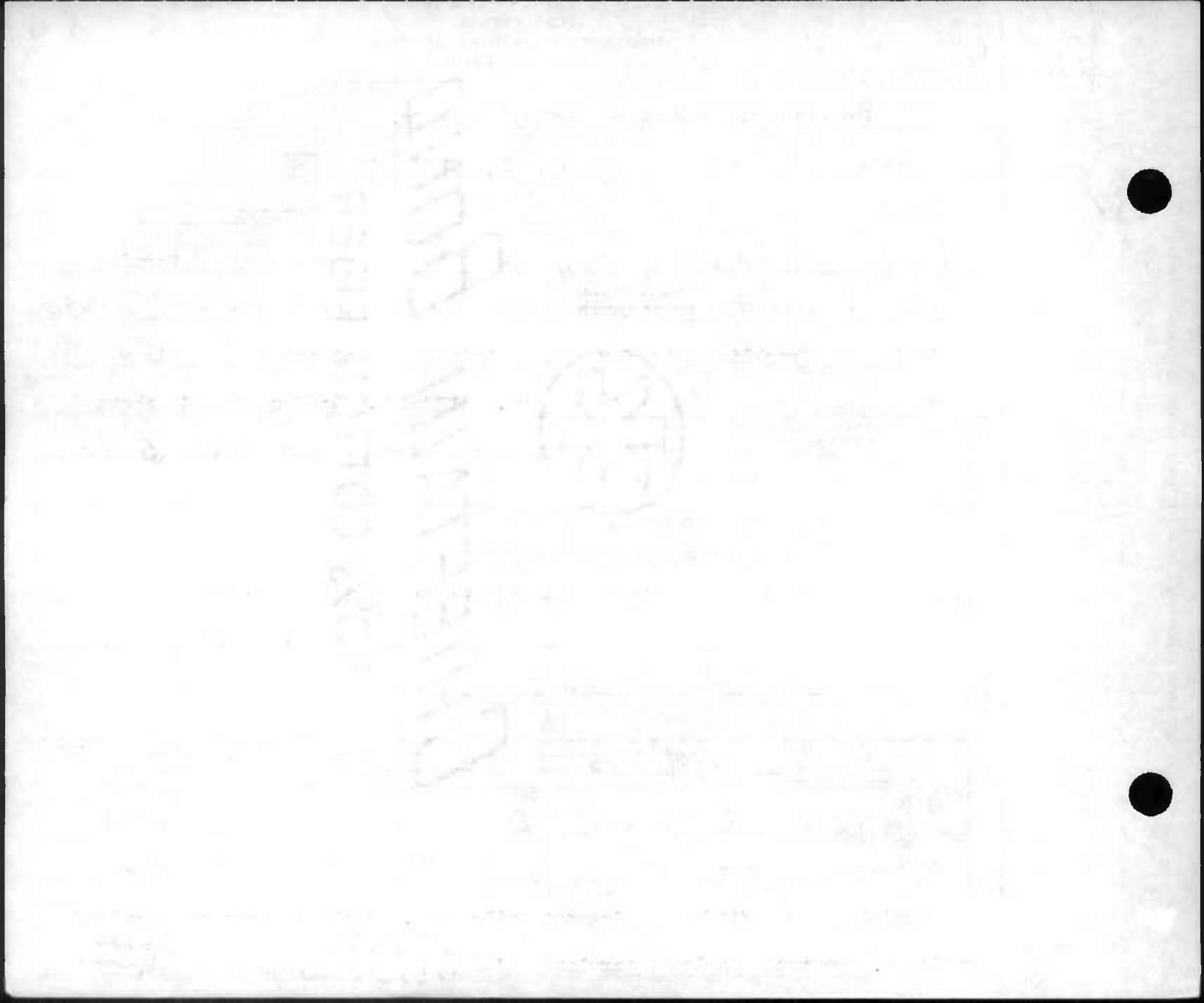


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8505288	
										REG. NO.	
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 2b HOUR								
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b 2 8 85			740 P.M.		
BENJAMIN FRANKLIN SHAFFER, Jr.											
3 SEX		4 RACE		5. DATE OF BIRTH MONTH 1 DAY 26 YEAR 13			6 AGE (IN YEARS LAST BIRTHDAY) 72			IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Garrett			MD.	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GARRETT CO Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b KIND OF BUSINESS OR INDUSTRY Farming				
13a STATE Md		13b COUNTY Garrett		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE Rt 4 Box 103 21550				
14. FATHER'S NAME FIRST Benjamin		MIDDLE Franklin		15. MOTHER'S MAIDEN NAME FIRST Lula			MIDDLE Catherine			LAST Elsey	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b SOCIAL SECURITY NO. 218-16-2776		17 INFORMANT Mrs. Mildred V. Shaffer, See #13 above							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic renal cell carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Prostate cancer, congestive heart failure, abdominal aortic aneurysm											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/19/84 to 2/8/85, and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death											
22b SIGNATURE Margaret A Kaiser MD		22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED 2/9/85							
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARGARET KAISER		22e ADDRESS 311 N 4th Oakland, Md 21550									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/11/85		23c NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cem.			23d LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____				
24 FUNERAL DIRECTOR NAME Bradley A. Stewart		ADDRESS Oakland, Maryland 21550		25a DATE REC'D. BY REGISTRY FEB 14 1985			25b DEPARTMENT REC'D. FROM				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner may be called in to examine the body.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8505289				
						REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR		
Donald	Clay		STEMPLE	February 14, 1985				5:08 p.m.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1914	6. AGE (IN YEARS LAST BIRTHDAY) 70	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.			
7a. BIRTHPLACE COUNTRY Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Garrett							
10. CITY OR TOWN OF DEATH Oakland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dry Cleaner	12b. KIND OF BUSINESS OR INDUSTRY Cleaning							
13a. STATE Maryland	13b. COUNTY Garrett	13c. CITY OR TOWN Oakland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Rt. 5 Box 10B 21550						
14. FATHER'S NAME FIRST Grover	MIDDLE C.	LAST Stemple	15. MOTHER'S MAIDEN NAME FIRST Nelle	MIDDLE	LAST Workman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 214-03-5676A	17. INFORMANT Eleanor J. Stemple - same as 13	ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTEN- SITY OF DISEASE BETWEEN ONSET AND DEATH				
(b) <i>Hypocardiac Heart Disease</i>										
(c) <i>Arteriosclerosis?</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>14 Feb 1985</u> to <u>14 Feb 1985</u> , that (I) (we) last saw the deceased alive on <u>14 Feb 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>A.E. Mance, M.D.</i>						DEGREE	22c. DATE SIGNED <i>15 Feb 1985</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.E. Mance, M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 2/17/85	23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Memorial	23d. LOCATION CITY OR TOWN Oakland	COUNTY Garrett	STATE Md.
24. FUNERAL DIRECTOR NAME Durst Funeral Home						25a. DATE REC'D. BY REGISTRAR FEB 20 1985	25b. REGISTRAR'S SIGNATURE <i>John Durst</i>			
ADDRESS Oakland, Md. 21550										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be apprised at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 05290		
1 - STATE REGISTRAR											REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Gilman			Henry				Sylvester		Feb 16		1985		11.15 AM	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Male			White		07 31 23		61 yrs		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
New Hampshire			USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Garrett							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Oakland			Dennett Rock manor Nsg. Home		Gen. manager		Sterling Processing							
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
MD			Garrett	Oakland	227 N. 2nd Street 21550									
14. FATHER'S NAME			MIDDLE		15. MOTHER'S MAIDEN NAME									
William			Henry		Ida									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES			WW II		Ruby Sylvester		227 North Second Street Oakland, MD 21550							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis</u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>95</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c) _____														
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN			COUNTY		STATE
22a. I certify that (I) (We) attended the deceased from <u>July 29</u> , 19 <u>85</u> , to <u>Feb 16</u> , 19 <u>85</u> , that (I) (We) last saw the deceased alive on <u>Feb 16</u> , 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) did not view the body after death.														
22b. SIGNATURE <u>Dr. B. L. Grant, MD</u>			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		<u>Feb. 16 1985</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Dr. B. L. Grant, MD			Third Street, Oakland, Maryland 21550											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN			COUNTY		STATE
Donation			2/16/85		W. Va. Un. Med. Center		Morgantown, Monongahela, W. Va.							
24. FUNERAL DIRECTOR NAME			ADDRESS		25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Bradley A. Stewart			Oakland, Maryland 21550		FEB 28 1985		Julie Anderson-Randall							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8505291						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Elva			Frances			Tasker						Feb 21		85			8:53 A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH	
female			white			MONTH 6 DAY 11 YEAR 1905			79 YRS			Md.		U.S.A.			Garrett	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Oakland			Garrett Co. Memorial									Housewife						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
Md.			Garrett			Kitzmiller			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Spring St 21538						
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME									
George						Tichine			Lizzie			Herman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			215 05 2206						Gloria Barnhouse			Kitzmiller, Md.			Terminal pneumonia days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			b) <i>arteriosclerosis</i>			DUE TO, OR AS A CONSEQUENCE OF			c) <i>deabetes mellitus</i>						years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION OF DEATH IN PART I.															<i>deabetes mellitus diabetic years</i>			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED									
<i>A.E. Mance M</i>												22e. ADDRESS			22f. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			A.E. Mance			22e. ADDRESS			Oakland, Md.						<i>2/28/85</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE						
Burial			2/24/85			Mt. Zion			Mt. Zion			Garrett Md.						
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
David A. Burdock			Kitzmiller, Md.			FEB 28 1985			<i>Julia Davidson Pendleton</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, *unless* retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, *page 3* should be detached for use as the burial/tranport permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical information portion of this certificate should be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 5 0 5 2 9 2					
						REG. NO.					
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Izetta		Mae		WRIGHT		February 7, 1985				730A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		March 7, 1913		71		YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Garrett					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Deer Park		Route #4, Box 74				Housewife		Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.		Garrett		Deer Park				Route #4, Box 74		21550	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
John		Warden		Smith		Mary		Hannah		Wonderly	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT		ADDRESS			
No		217-22-2345				Mrs. Nellie P. Kettlewell, See #13 above					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.						DUE TO, OR AS A CONSEQUENCE OF Cholestein					
(b)						DUE TO, OR AS A CONSEQUENCE OF Carcinoma of the breast					
(c)						Months					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Opercating, Atherosclerosis.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 21)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from <u>Oct 1</u> , 19 <u>81</u> , to <u>Feb 7</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>Feb 6</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (I did not) view the body after death.											
22b. SIGNATURE <i>Thomas Mance</i>		22c. DEGREE J.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 2-7-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Dr. Thomas Mance, DO						Third St., Oakland, Md. 21550					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE	
burial		2/10/85		Ferndale Cemetery		Oakland		Garrett		Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Bradley A. Stewart		Oakland, Maryland 21550				FEB 14 1985		<i>John K. Kite</i>			

